ARMY MEDICINE
Serving To Heal...Honored To Serve

US Army Patient Safety Center

Johns Hopkins Fall Assessment Tool

Quality Management Division
HQ, US Army Medical Command
Fort Sam Houston, TX

1 June 2011

Background

- All patients regardless of age are at an increased risk for falling in a hospital setting. Fall and injury prevention continues to be a considerable challenge across the care continuum.
  - Injuries from falls are the 6th most commonly reported sentinel event
  - MEDCOM 2010 data revealed 599 inpatient falls; 69 falls resulted in harm

Purpose

- To standardize endorsed evidence based fall risk assessment tools across all Army Medical Treatment Facilities (MTFs) that provide inpatient nursing care in the electronic medical record (Essentris).
  - In collaboration with the Patient Caring Touch initiative
  - Implementation of tools recommended by the Falls Working Group (Nov 2009) and purchased by the MEDCOM Patient Safety Center

Goal

- Decrease patient fall events and harmful injuries
- Decrease variation in assessment, interventions, procedures and documentation of falls risk and increase prevention of falls across Army MTFs.

The Johns Hopkins Adult Fall Risk Assessment Tool

- Stratifies patient interventions based on low, moderate and high risk for falls.
  - Low: 5 points or less
  - Moderate: 6-12 points
  - High: 13 points or greater
- Interventions populated for each risk category.

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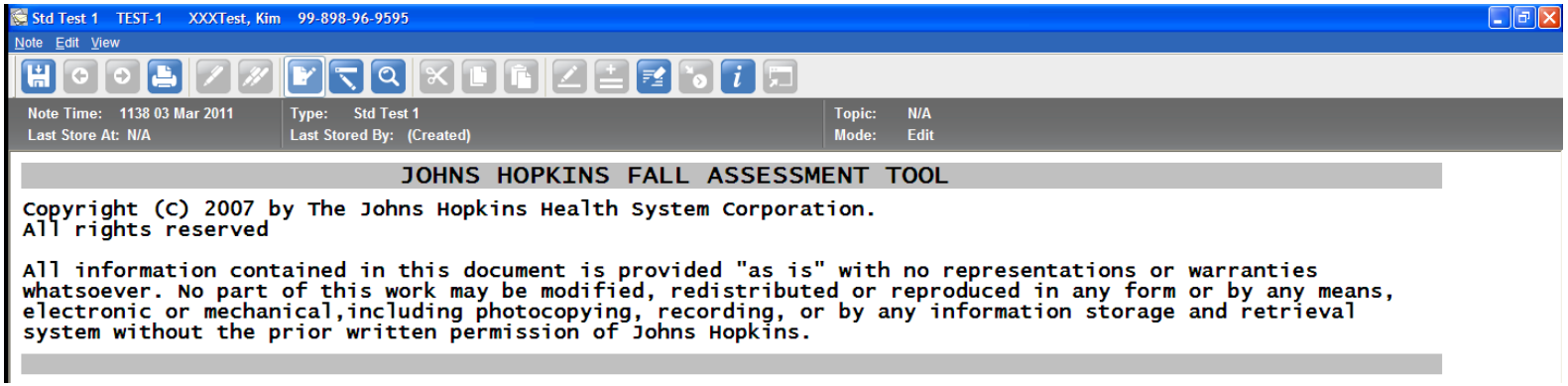
John's Hopkins
Fall Assessment Tool
Essentris Documentation

Main Screen, includes Fall Risk Factor Category

Select "Patient is at Low Fall Risk" below or "Patient is at High Fall Risk" below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Note Time: 1138 03 Mar 2011
Last Store At: N/A
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JOHNS HOPKINS FALL ASSESSMENT TOOL
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Fall Risk Factor Category

Scoring not completed for the fo

- ☐ Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.
- ☐ Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient has experienced a fall during this hospitalization. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient is deemed high fall-risk per protocol (e.g. seizure precautions). Implement high fall-risk intervent throughout hospitalization per protocol.

☐ CALCULATE FALL RISK SCORE

Select Patient Risk Level

☐ Patient is at Low Fall Risk

sk

Step 1: Assess Fall Risk Factor Category; if risk category applies, initiate interventions as assessed.

Step 2: If Fall Risk Factor Category above not applicable, select Calculate Fall Risk Score. (See next slide)

If patient Fall Risk Factor Category applies, select high or low risk as assessed.

Calculate Fall Risk Score

Based on Total Points: select “Patient is at Low Fall Risk”, “Patient is at Moderate Fall Risk” or “Patient is at High Fall Risk”

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Step 3: Assess patient fall risk score from drop-down choices below. Selection will auto-populate fall risk score

[X] CALCULATE FALL RISK SCORE

	POINTS
AGE	
FALL HISTORY	
ELIMINATION, BOWEL AND URINE	
MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS	
PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDs, ETC	
MOBILITY: Requires assistance or supervision for mobility, transfer, or ambulation	
COGNITION: Altered awareness of immediate physical environment	
MOBILITY: Unsteady gait	
MOBILITY: Visual or auditory impairment affecting mobility	
COGNITION: Impulsive	
COGNITION: Lack of understanding of one's physical and cognitive limitations	
Total Points	

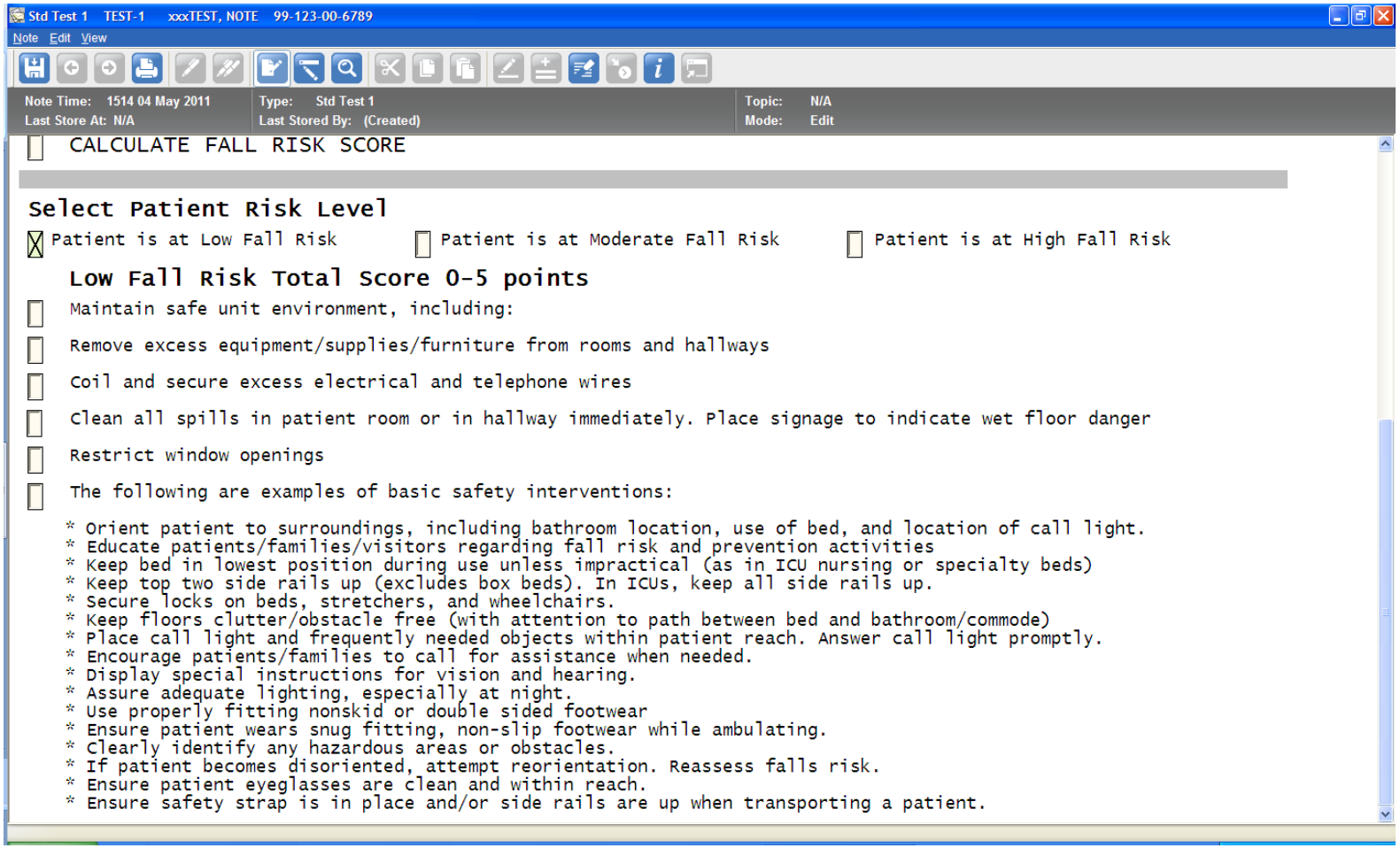
Low risk = 0-5 Total Points
Moderate risk = 6-13 Total Points
High risk > 13 Total Points

Step 3: Assign Risk Level as above

Select Patient Risk Level

Low Fall Risk Interventions

Expanded view of low risk interventions, document as appropriate.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Last Stored By: (Created)
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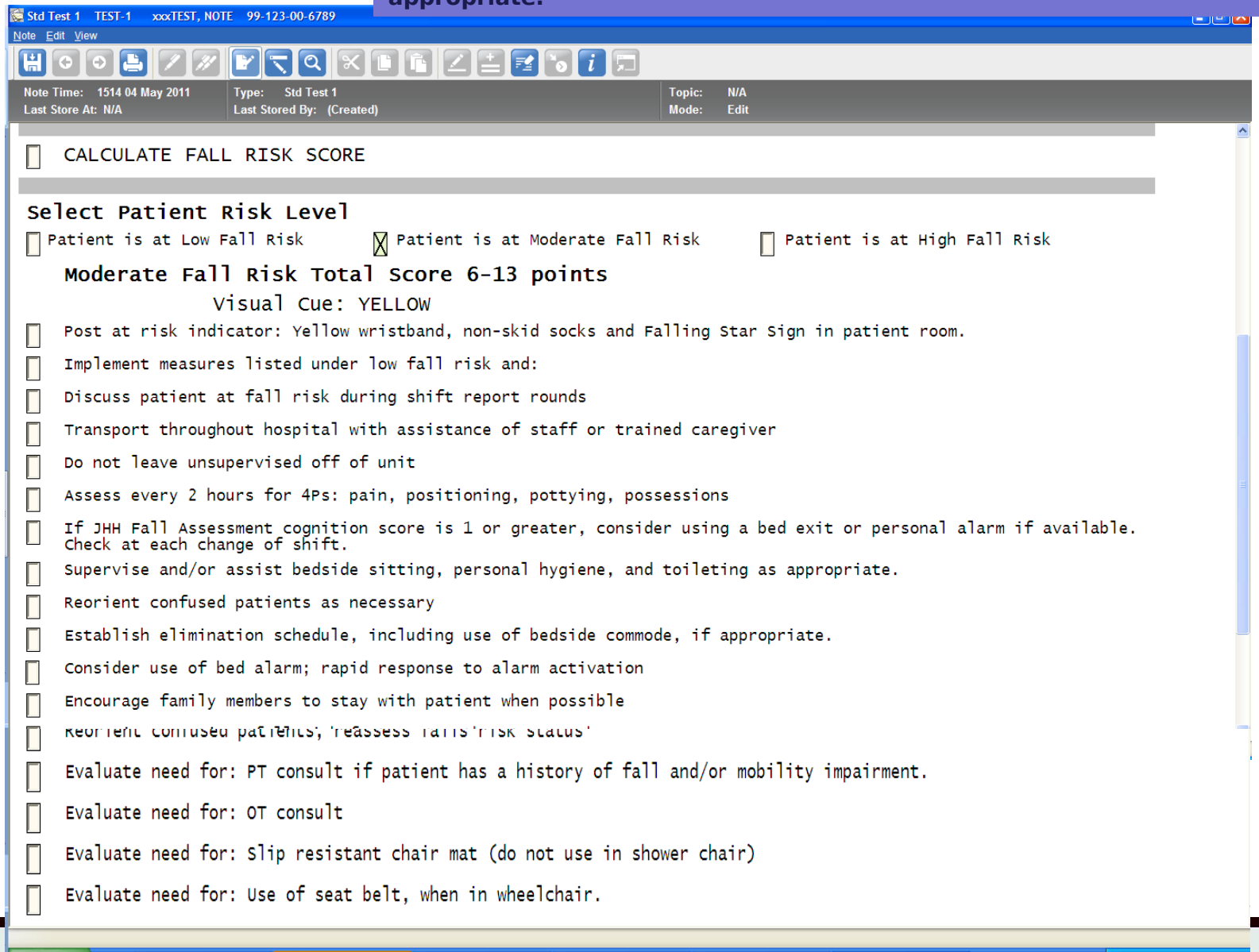
CALCULATE FALL RISK SCORE
Select Patient Risk Level
Patient is at Low Fall Risk
Patient is at Moderate Fall Risk
Patient is at High Fall Risk
Low Fall Risk Total Score 0-5 points
Maintain safe unit environment, including:
Remove excess equipment/supplies/furniture from rooms and hallways
Coil and secure excess electrical and telephone wires
Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger
Restrict window openings
The following are examples of basic safety interventions:
* Orient patient to surroundings, including bathroom location, use of bed, and location of call light.
* Educate patients/families/visitors regarding fall risk and prevention activities
* Keep bed in lowest position during use unless impractical (as in ICU nursing or specialty beds)
* Keep top two side rails up (excludes box beds). In ICUs, keep all side rails up.
* Secure locks on beds, stretchers, and wheelchairs.
* Keep floors clutter/obstacle free (with attention to path between bed and bathroom/commode)
* Place call light and frequently needed objects within patient reach. Answer call light promptly.
* Encourage patients/families to call for assistance when needed.
* Display special instructions for vision and hearing.
* Assure adequate lighting, especially at night.
* Use properly fitting nonskid or double sided footwear
* Ensure patient wears snug fitting, non-slip footwear while ambulating.
* Clearly identify any hazardous areas or obstacles.
* If patient becomes disoriented, attempt reorientation. Reassess falls risk.
* Ensure patient eyeglasses are clean and within reach.
* Ensure safety strap is in place and/or side rails are up when transporting a patient.

Moderate Fall Risk Interventions

Expanded view of Moderate Fall Risk Interventions, document as appropriate.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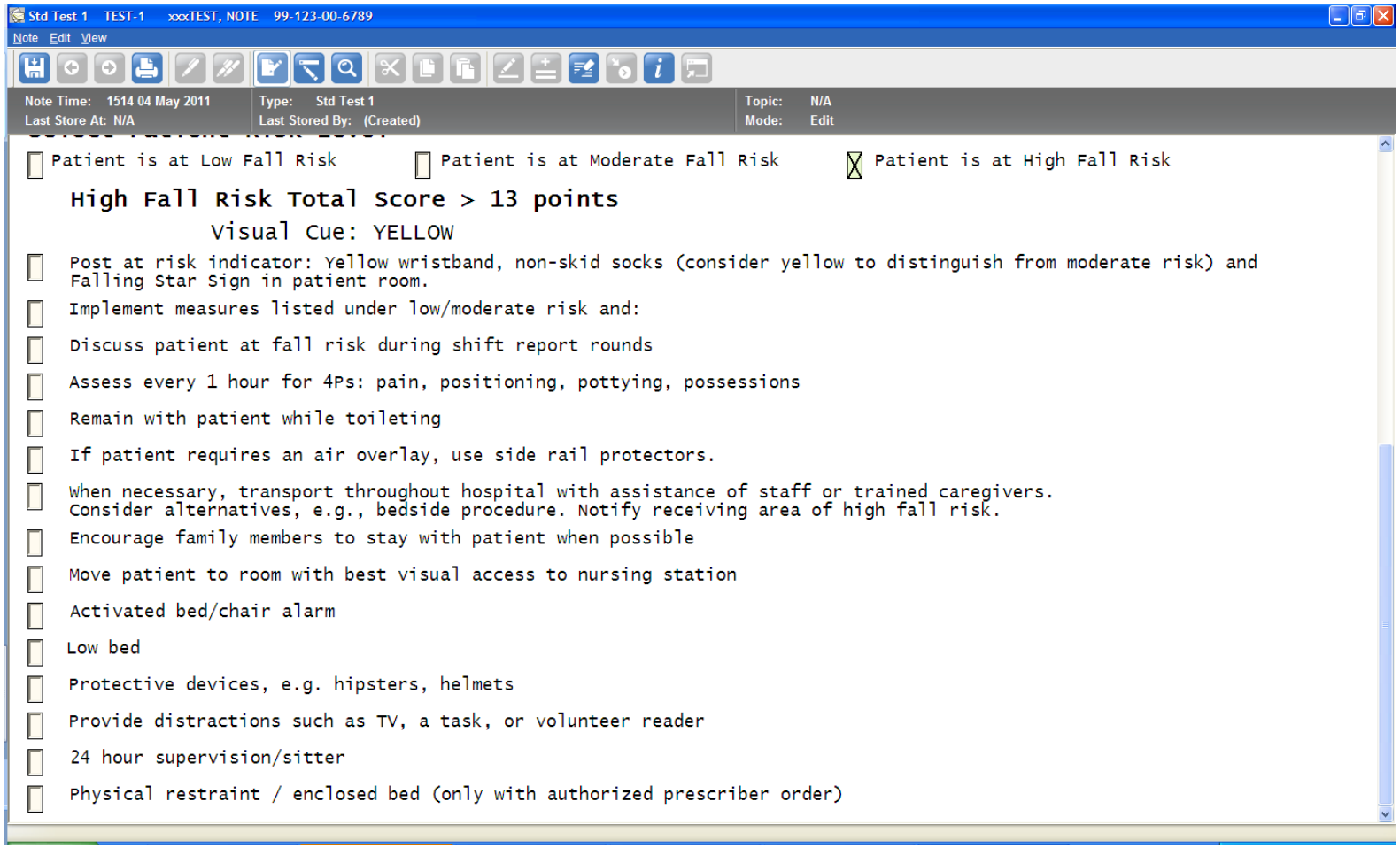
Mode: Edit
CALCULATE FALL RISK SCORE
Select Patient Risk Level
Patient is at Low Fall Risk
Patient is at Moderate Fall Risk
Patient is at High Fall Risk
Moderate Fall Risk Total Score 6-13 points
Visual Cue: YELLOW
Post at risk indicator: Yellow wristband, non-skid socks and Falling Star Sign in patient room.
Implement measures listed under low fall risk and:
Discuss patient at fall risk during shift report rounds
Transport throughout hospital with assistance of staff or trained caregiver
Do not leave unsupervised off of unit
Assess every 2 hours for 4Ps: pain, positioning, pottying, possessions
If JHH Fall Assessment cognition score is 1 or greater, consider using a bed exit or personal alarm if available. Check at each change of shift.
Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate.
Reorient confused patients as necessary
Establish elimination schedule, including use of bedside commode, if appropriate.
Consider use of bed alarm; rapid response to alarm activation
Encourage family members to stay with patient when possible
Reorient confused patients; reassess falls risk status
Evaluate need for: PT consult if patient has a history of fall and/or mobility impairment.
Evaluate need for: OT consult
Evaluate need for: Slip resistant chair mat (do not use in shower chair)
Evaluate need for: Use of seat belt, when in wheelchair.

High Fall Risk Interventions

Expanded view of high risk interventions, document as appropriate.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Mode: Edit
☐ Patient is at Low Fall Risk
☐ Patient is at Moderate Fall Risk
☒ Patient is at High Fall Risk
High Fall Risk Total Score > 13 points
Visual Cue: YELLOW
☐ Post at risk indicator: Yellow wristband, non-skid socks (consider yellow to distinguish from moderate risk) and Falling Star Sign in patient room.
☐ Implement measures listed under low/moderate risk and:
☐ Discuss patient at fall risk during shift report rounds
☐ Assess every 1 hour for 4Ps: pain, positioning, pottying, possessions
☐ Remain with patient while toileting
☐ If patient requires an air overlay, use side rail protectors.
☐ When necessary, transport throughout hospital with assistance of staff or trained caregivers. Consider alternatives, e.g., bedside procedure. Notify receiving area of high fall risk.
☐ Encourage family members to stay with patient when possible
☐ Move patient to room with best visual access to nursing station
☐ Activated bed/chair alarm
☐ Low bed
☐ Protective devices, e.g. hipsters, helmets
☐ Provide distractions such as TV, a task, or volunteer reader
☐ 24 hour supervision/sitter
☐ Physical restraint / enclosed bed (only with authorized prescriber order)

Nursing Fall Prevention CPG

- In collaboration with the Patient Touch System of Care, the clinical practice guideline on nursing care to support this initiative can be found at: https://www.qmo.amedd.army.mil/NurseCPG/NurseCPG.html
- Additional tools to support fall prevention can be accessed through Mosby's On-line.